

AD-A265 453

(2)

STUDY
PROJECT

The views expressed in this paper are those of the author and do not necessarily reflect the views of the Department of Defense or any of its agencies. This document may not be released for open publication until it has been cleared by the appropriate military service or government agency.

A DEPARTMENT OF DEFENSE
HEALTH SERVICE AGENCY
(A SINGLE SERVICE HEALTH
SERVICE SUPPORT SYSTEM)

BY

LIEUTENANT COLONEL JAMES H. HOPKINS
United States Army

DISTRIBUTION STATEMENT A:

Approved for public release.
Distribution is unlimited.

DTIC
ELECTE
JUN 08 1993
S A D

USAWC CLASS OF 1993



U.S. ARMY WAR COLLEGE, CARLISLE BARRACKS, PA 17013-5050

93-12786



93 6 07 140

USAWC MILITARY STUDIES PROGRAM PAPER

The views expressed in this paper are those of the author and do not necessarily reflect the views of the Department of Defense or any of its agencies. This document may not be released for open publication until it has been cleared by the appropriate military service or government agency.

A DEPARTMENT OF DEFENSE HEALTH SERVICE AGENCY
(A SINGLE SERVICE HEALTH SERVICE SUPPORT SYSTEM)

AN INDIVIDUAL STUDY PROJECT

by

Lieutenant Colonel James H. Hopkins
United States Army

Colonel Lawrence B. Goodwin
Project Advisor

DISTRIBUTION STATEMENT A: Approved for public
release; distribution is unlimited.

U.S. Army War College
Carlisle Barracks, Pennsylvania 17013

Accession For	
NTIS	CRA&I
DTIC	148
Unpublished	
Justification	
By	
Distribution	
Availability Codes	
Dist	Avail and/or Special
A-1	

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION UNCLASSIFIED		1b. RESTRICTIVE MARKINGS	
2a. SECURITY CLASSIFICATION AUTHORITY		3. DISTRIBUTION/AVAILABILITY OF REPORT Approved for public release.	
2b. DECLASSIFICATION/DOWNGRADING SCHEDULE		Distr. is unlimited	
4. PERFORMING ORGANIZATION REPORT NUMBER(S)		5. MONITORING ORGANIZATION REPORT NUMBER(S)	
6a. NAME OF PERFORMING ORGANIZATION U.S. ARMY WAR COLLEGE	6b. OFFICE SYMBOL (If applicable)	7a. NAME OF MONITORING ORGANIZATION	
6c. ADDRESS (City, State, and ZIP Code) ROOT HALL, BUILDING 122 CARLISLE, PA 17013-5050		7b. ADDRESS (City, State, and ZIP Code)	
8a. NAME OF FUNDING/SPONSORING ORGANIZATION	8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER	
8c. ADDRESS (City, State, and ZIP Code)		10. SOURCE OF FUNDING NUMBERS	
		PROGRAM ELEMENT NO.	PROJECT NO.
		TASK NO.	WORK UNIT ACCESSION NO.
11. TITLE (Include Security Classification) A Department of Defense Health Service Agency (A Single Service Health Service Support System)			
12. PERSONAL AUTHOR(S) LTC JAMES H. HOPKINS			
13a. TYPE OF REPORT INDIVIDUAL	13b. TIME COVERED FROM _____ TO _____	14. DATE OF REPORT (Year, Month, Day) 93 Mar 21	15. PAGE COUNT 40
16. SUPPLEMENTARY NOTATION			
17. COSATI CODES		18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)	
FIELD	GROUP	SUB-GROUP	
19. ABSTRACT (Continue on reverse if necessary and identify by block number) Since 1947 there have been numerous inquiries and studies concerning the consolidation of the Armed Forces Health Services into a single health service support system. This recommendation has met both opposition and support at various times from Congress, the Joint Chief of Staffs, the Military Departments and the Services Medical Departments. The Department of Defense is entering a new era and to meet the requirements being placed on it by the National Command Authority and the Congress, it must review, revise, and reorganize to accomplish its missions. This study is one alternative of how the Army Medical Department under the guidance and leadership of the Assistant Secretary of Defense for Health Affairs can accomplish those requirements.			
20. DISTRIBUTION/AVAILABILITY OF ABSTRACT <input checked="" type="checkbox"/> UNCLASSIFIED/UNLIMITED <input type="checkbox"/> SAME AS RPT. <input type="checkbox"/> DTIC USERS		21. ABSTRACT SECURITY CLASSIFICATION	
22a. NAME OF RESPONSIBLE INDIVIDUAL LAWRENCE B. GOODWIN, JR., COL, IN		22b. TELEPHONE (Include Area Code) 717-245-3455	22c. OFFICE SYMBOL DMSPO

ABSTRACT

AUTHOR: James H. Hopkins, LTC, USA

TITLE: A Department of Defense Health Service Agency
(A Single Service Health Service Support System).

FORMAT: Individual Study Project

DATE: 21 March 1993 Pages: 40 CLASSIFICATION: Unclassified

Since 1947 there have been numerous inquiries and studies concerning the consolidation of the Armed Forces Health Services into a single health service support system. This recommendation has met both opposition and support at various times from Congress, the Joint Chief of Staffs, the Military Departments and the Services Medical Departments. The Department of Defense is entering a new era and to meet the requirements being placed on it by the National Command Authority and the Congress, it must review, revise, and reorganize to accomplish its missions. This study is one alternative of how the Army Medical Department under the guidance and leadership of the Assistant Secretary of Defense for Health Affairs can accomplish those requirements.

TABLE OF CONTENTS

ABSTRACT.....	ii
INTRODUCTION.....	1
BACKGROUND.....	3
READINESS AND OPERATIONAL REQUIREMENTS.....	9
JOINT DOCTRINE AND REGULATIONS.....	12
JOINT HSS DOCTRINE.....	17
ILLUSTRATION-ECHELONS OF HEALTH CARE.....	19
PEACETIME HEALTH CARE DELIVERY.....	21
WHERE WE ARE TODAY.....	24
PLANNING MEDICAL SUPPORT.....	25
A SINGLE SERVICE HSS SYSTEM.....	28
CONCLUSION.....	37
ACRONYMS.....	39
ENDNOTES.....	41
BIBLIOGRAPHY.....	43

INTRODUCTION.

President Eisenhower once stated, " separate ground, sea and air warfare are gone forever. If ever again, we should be involved in war, we will fight it..as one single concentrated effort..strategic and tactical planning must be completely unified, combat forces organized into unified commands.."¹. This prediction has continued to evolve doctrinally through the years toward a more combat effective armed forces. Now, the national budget has developed as an even more imperative stimulus for concentrating efforts.

If the assumption "budgets drive strategies" is correct, then the military forces will become smaller. Senator Nunn in a speech to the Senate related a conversation he had with Admiral Crowe the previous Chairman, Joint Chiefs Of Staff (CJCS). Admiral Crowe stated, "At every point in our history as a country, when we faced the end of a period of military crisis and the start of an era of relative peace, we deal with our defense policy in a two step process. The first step is to cut the defense budget. And when we do that we usually get a smaller version of what we currently have. The second step is to shape a new force in light of the changed circumstances. Admiral Crowe said that we always tend to do the first step and fail to follow through with the second. That is why, generals and admirals are usually prepared to fight the last war" ². A Congress that continues to support downsizing the armed services, a multitude of obscure military threats, and a President elected on the promise to strengthen the economy and reduce the national deficit

guarantees the first step.

If Admiral Crowe is predicting the future by quoting the past, then it is time to take heed. Is it better to have someone else change the armed service by authorizing less, even though the types of mission are increasing? Or is it better to drive changes that are effective and do more without duplication. "The process of shaping a new force in light of changed circumstances," as Admiral Crowe stated, must be accomplished by objectively reviewing functional areas. This study reviews historical background, operational and readiness requirements, joint doctrine, peacetime health care delivery, and medical assets used for planning; and then relates this review to the armed services' health service support (HSS) functional areas. The thesis of this study is to examine the feasibility of a single Department of Defense (DoD) Health Service Agency (HSA) and how to best consolidate the three services medical assets.

The Armed Services Medical Department's first mission is to "Conserve the Fighting Strength". To succeed, this system must be designed, organized, resourced, and trained for war. Its second mission, sometimes considered the most important, is health care for active duty family members, retirees, and retirees' family members. As health care delivery programs are enacted to minimize costs, they must care for the military family and simultaneously contribute to the go-to-war mission.

As the armed services becomes smaller and the HSS system is developed to meet health care demands, it must be synchronized

with the national security strategy and the national military strategy. It must be responsive to both the deliberate and crisis response systems.

The DoD HSS system is responsible for more requirements than any existing HSS system. There are no civilian HSS corporations or other national military HSS systems tasked to maintain, at such a high level, the balance between peacetime health care, readiness, and contingencies missions. There are no comparisons. Does this mean, there is no room for improvement?

BACKGROUND.

Since the National Security Act of 1947, there have been numerous studies and inquiries concerning the feasibility of a single DoD HSA. Congress' goal for this organization is to reduce costs while maintaining health care. As health care costs increases, this initiative becomes more attractive, if feasible.

The Army Surgeon General, Major General R.W. Bliss in 1947 stated, "We do not have the means to support three separate medical services". Since then, there have been numerous commissions, boards, and committees. The primary recommendations have been to organize joint and coordinating work groups, none which had command authority, so they depended on the services' approval and implementation. Far too many times, the recommendations have been diluted by the services' Medical or Military Departments.

As early as March, 1949 a handwritten memo from General Eisenhower to the SECDEF recommended the following: "The JCS unanimously recommended the SECDEF immediately institute studies and measures intended to produce, for support of the three fighting services, a complete unified and amalgamated (single) Medical Service."⁵ The same generals of the JCS, when they assumed their roles as Chiefs of the Military Services, rejected the recommendations of the studies in favor of retaining their respective independent health care systems.

In the 1940 and 50's, the U.S. was experiencing a shortage of medical personnel throughout the country. It was believed that the Federal HSS activities were extremely expensive. As a result, two studies were conducted by the Hoover Commission. Its first report was submitted to the Congress in 1949 and the second in 1955⁶. The Hoover Commission reported numerous areas in which there were duplications of effort, lack of coordination, and serious waste. The areas included were (not all inclusive) the following:

1. Medical care to patients.
2. Research in the field of health.
3. Hospital construction.
4. Preventive health services.
5. Education and training of health personnel.
6. Medical supply (and equipment).
7. Organization for (civil) disaster.

These findings were selected to emphasize that some problems

do not seem to change.

In a 1979, the Secretary of the Air Force, Donald Rice directed the "Defense Resource Management Study (DRMS)". The study concluded:

"With the benefit mission solely or primarily in mind, consolidation, perhaps even the creation of a single, unified DOD health care agency, seems attractive. But with the readiness mission primarily in mind, the current decentralized system, more closely linked to the deploying forces, seems better. With the realization that desirable objectives can often conflict, the DRMS opts for a more concerted effort to pursue both missions thru the current, decentralized system. If the recommendations made earlier in this study are implemented and the system does not improve enough, the question of consolidation should be reopened, (underlining added by author of the study)?".

In May, 1982 the Senate Armed Service Committee (SASC) directed the SECDEF to study the feasibility and benefits to be gained by creating a Defense Health Agency (DHA)*. This requirement stemmed from concerns related to medical readiness, peacetime health care delivery, and quality assurance. The study completed by System Research and Applications Corporations (SRA) in Aug 83, concluded the armed services' HSS could benefit from a more centralized integration of the three service medical departments and it would be more cost efficient.

The Goldwater-Nichols DoD Reorganization Act of 1986 is considered a major milestone in the evolution of an armed

services oriented to unified command and joint operations. This act strengthens the positions of the CJCS, the authority of the unified and specified commanders, and establishes rules of engagement on the budget. Unfortunately, the act does not provide a solid requirement to conduct joint operations to the degree necessary to overcome service duplication. Title V of the DoD Reorganization Act reaffirms the responsibility of the Secretary of the Services to include raising, equipping, maintaining, servicing and administering the separate services, including resourcing⁹. These responsibilities, although absolutely necessary, breeds duplication. This is discussed further under joint doctrine, but in summary the Goldwater-Nichols Act does not make joint operations automatic.

The FY 1989 Defense Authorization Act also expressed concern about the need for a single unified approach to medical programs¹⁰.

The next year, the House Appropriations Committee Report on the FY 1990 Defense Appropriations Act directed a reorganization of DOD's medical programs into a more centralized organization with one person in charge and four deputies. This proposal was rejected by the Senate Appropriations Committee in order to provide the Assistant Secretary of Defense for Health Affairs (ASD/HA) time to analyze the needs of health management and organization.

In response, the ASD(HA) forwarded to Congress his Report on the Reorganization of Military Health Care. This report

initiated what exists today. The reorganization included:

1. Centralized accountability and decentralized execution.
2. Participation among the three Surgeon Generals and the ASD(HA) in an organization engaged in managing and overseeing a reorganized HSS system.
3. Assuring that readiness remain central to the organizational design.
4. Establishment of a single accountable individual or office within the DOD for health issues which would, among other things, control the medical budget.

In November 1990, a memorandum from the Deputy Secretary of Defense requested that the Director of Administration and Management conduct a study to determine the optimum organization of medical functions within the Department of Defense to achieve the following objectives:

1. Provide medical services and support to the armed forces during combat operations.
2. Provide medical support in peacetime to members of the armed forces, their dependents, and others entitled to medical care provided by DoD.
3. Achieve fully both objectives at the lowest feasible cost to the taxpayer.

The result of the study confirmed a central health care management structure could produce significant improvements and costs savings. Unfortunately, the study is long on peacetime health care recommendations and short on readiness to conduct the

medical wartime mission.

As a result of a 1985 Congressional directive to ASD(HA) to cure medical readiness by 1992, FORSCOM CONPLAN 7300-90, Integrated CONUS Medical Mobilization Plan, dated 1 July 1990, was developed. This CONPLAN was directed at developing a wartime and national disaster response solution to the mission that faces FORSCOM. The purpose of this plan is to ensure integration of the appropriate portions of the services' mobilization plans, the Department of Veterans Affairs, the Department of Defense Contingency Hospital System and the National Disaster Medical System...". The mission statement continues and becomes more complicated by its attempt to organize the services who would most likely be heavily committed to deploying forces and a multitude of government agencies that have had problems communicating previously. This document was developed by the FORSCOM Surgeon's Office because they had the responsibility, but no authority. It is an admirable effort and a step in the right direction, but will need intense management and annual exercising of the system.

Senator Nunn in 1992 speaking to the Senate addresses his concern about the duplication of roles and missions in the armed services. He specifically singles out the services' Medical Corps, Dental Corps, and Nurse Corps. Streamlining the logistics, administration and management duplication among the services could save tens of billions annually, he stated. Where Senator Nunn's objectives in the roles and missions development

will lead the armed services' HSS is only a guess¹².

Given all these studies, inquiries and directives; the question must be posed, "How have the services managed to maintain their separate HSS systems for this long"?

READINESS AND OPERATIONAL REQUIREMENTS.

What drives the medical departments' readiness and operational requirements? Some say it is the threat. That is only one part of it. If US national interests remain the same, even after a change in Presidents; then the services' medical forces must be responsive to the defense policies developed by the Secretary of Defense to support the national strategies of the President. Will Congress appropriate the resources to effectively execute these missions?

The SECDEF's report to Congress states the NCA expects the DoD HSA to provide worldwide medical support during all military operations and support crises in the US, as well. Examples of the variety and depth of recent DoD HSS missions are: Joint Task Force Los Angles; disaster relief efforts in Florida and Louisiana (Hurricane Andrew) and Hawaii (Hurricane Iniki); Haitian refugee relief efforts at Guantanamo Bay, Cuba; provision of hospital equipment sets and technical expertise to the Republics of Georgia and Kyrgzstan; and the UN Peacekeeping Forces deployed in the Republics of Croatia and Somalia. Additionally, DoD's security assistance program provides medical

material and training to over 50 countries¹³.

As a result of the Base Realignment and Closure Act (BRAC), 17 hospitals have closed or are scheduled to close. Joint service planning efforts are continuing to develop and implement major initiatives such as the coordinated care program to maintain effective health care for eligible beneficiaries remaining in those areas.

Reviewing threats the U.S. might face, DoD developed a set of force deployment objectives. These objectives reflect deployment demands of major regional crises (MRC) and smaller contingencies¹⁴. For a MRC, the goal is:

1. Initial Forces. Light Army and Marine elements, several fighter aircraft squadrons, and one or more carrier battle groups are delivered in a matter of days as the initial response.

2. Early-Arriving Forces. Next in priority to arrive are one or more Marine Expeditionary Brigade's (MEB), at least one heavy Army Brigade, plus additional fighter squadrons and carrier battle groups. These units normally would be in a defensive posture based on the threat.

3. Additional Ground Forces. The remainder of a heavy Army Corps and a Marine Expeditionary Force (MEF) is delivered within the first six weeks. The cumulative combat forces in the region would stabilize the conflict until additional forces arrive.

4. Remaining Forces. The next priority are the combat and support forces needed for offensive operations. The ultimate size of the force depends on the threat, the political and military

objectives, and the theater commander's campaign plan.

Doctrine dictates that medical and logistical support are services' responsibilities. Given the Base Force as outlined by the CJCS, the response time required, the transportation feasibility studies to execute the deployment objectives, and present medical force organizations; this cannot be done without maximum unity of effort.

To add to the list of missions that must be planned and resourced, TRADOC is now defining operations other than war¹⁵. These include: post-conflict, nation assistance, natural disasters, fire fighting operations, man-made disasters, support to law enforcement and other agencies, refugee resettlement operations, security augmentation, nation building and operational support, humanitarian assistance operations, peacekeeping operations, shows of force, NEO, counterdrug operations, anti-terrorism, and support to insurgency and counter-insurgencies. HSS plays a major role in most of these missions.

A draft Medical Programming Guidance was circulated to obtain input for a unified medical program. The draft guidance covered the following:

1. The services will program a total medical force capable of immediate support for contingencies based on the scenarios found in the DPG and the new defense strategy.
2. JOPS MPM will be used to predict wartime bed requirements supporting at a minimum a 15 day theater evac policy during peak

demand for all theaters and contingencies. Each service will translate this data into its medical force structure. The TO&E or Service organizational equivalents for this structure will be the basis for the manpower requirements.

This draft was used, because it exemplifies normal planning guidance. Each service plans to support only themselves. The services, planning separately instead of jointly, produce overlaps causing duplication and gaps in the continuum of support plans. Duplication to a degree is necessary, but it is the gaps which become critical.

A final note to the significance of this section on readiness and operational requirements. As stated, there are no civilian hospital corporations or other national military medical systems that must contend with all these requirements and maintain the daily health care delivery without interruptions. Is this a vote for a HSS system with the authority to efficiently direct resources, therefore providing more unity of effort?

JOINT DOCTRINE AND REGULATIONS.

Joint doctrine is rapidly evolving and maturing steadily. With some ninety or more publications being developed, reviewed, revised, and tested; it is understandable that the disconnects will take sometime to be worked out. To obtain an appreciation, a few extracts are provided:

1.JCS Pub 2

a. PP.1-2 par 1-3. Organization for Purposes Other Than Operational Direction.

Text. "Each of the Military Departments and Services, coordinating as appropriate with the others and with the unified and specified commands, has the responsibility for organizing, training, equipping, and providing forces to fulfill certain specific combatant functions and for administering and supporting such force. This responsibility includes the formulation of tactical and technical doctrine for the combatant functions involved, the internal structure and composition of forces, unit and individual training, and the types and quantities of equipment and supplies to be developed and procured."

Comment: The differences in the Military Departments and combatant commands responsibilities are known. The Military Departments are in the resourcing business. The Theater CINCs are developing joint OPLANS to accomplish their missions. Unfortunately, this section does not delineate those differences. As a result, it is many times interpreted as operational and does not promote joint operations.

b. PP. 1-8. The Principle of Support.

Text. "The forces developed and trained to perform the primary functions assigned to one Service will be employed to support and supplement the other Services when such participation will result in increased effectiveness and contribute to the accomplishment of military objectives."

Comment: This must happen in the deliberate planning

stages, because the end product of the process is normally resourced and no one wants to lose resources. It more readily occurs during a crisis response process or an overseas BRAC process, because then it is feasible, logical, and operationally necessary.

c. PP. 1-4. par 1-9. Broad Objectives.

Text. "Prevention of unnecessary duplication or overlapping among the Services by using personnel, intelligence, facilities, equipment, supplies, and services of any or all Services in cases where military effectiveness and economy of resources will thereby be increased."

Comment: This needs to be directed more toward the functional areas. It is too broad in context. Doctrine is not directive, but it must be highly descriptive.

d. PP.3-62. par 3-93. Medical and Dental Services.

Text. "The CINCs are responsible for coordination of medical and dental services within the command."

Comment: First, in JCS PUB 2, this is all it says about medical. Second, Joint Pubs 1 and 2 summarily state "do things joint". At the same time, the CJCS places a ceiling on joint positions without regard to functional areas. In the unified command a priority process is devised, the combat planners get first choice, and by the time the slots reach the combat service support, there are more requirements than authorizations. Joint operations in the CSS arena are where duplication can be eliminated the easiest. Commonality of equipment and supplies

would enhance this capability tremendously. How it can be approached medically is discussed later.

2. JS Admin Pub 1.1, Organization and Functions of the Joint Staff. JCS. 1 October 1988.

a. Section 5. pp.III-5-8,(45). Logistics Directorate.

Text. "Serves as the Joint Staff POC for matters pertaining to joint medical planning, resource requirements, hospitalization, casualty evacuation, patient regulating, medical pre-positioning, and host-nation support."

Comment: Logistics officers do not think in medical terms. Given any situation that requires a reduction in force or economy of force, it immediately becomes an issue between medical and logistics. The initial staff recommendations are heard by the chief logistician and, normally, logistics is given the higher priority. HSS was designed as a special staff position to the commander. In commands where it is separate from logistics, there is a demonstrated higher level of responsiveness. This is attributed to the elimination of layers between the Commander and the Surgeon. The Commander should make the decision based on advice from the Surgeon, not the logistics officer. The previous description of medical in JCS Pub 2 is a good example. In that publication, medical is under logistics. Finally, HSS is one of today's highest visibility subjects in both politics and government. It stands to reason that military leaders would place their Command Surgeon's in a more direct decision path than subordinate them to logistics.

4. Test Pub. JCS Pub 3-0, Doctrine for Unified and Joint Operations, The Joint Chiefs of Staff, Washington D.C. 20318-7000, Jan 1990.

a. Chapter II, Unified Operations in Peace. pp.II 2-3.
Logistic Considerations.

Text. "Each military Service has the responsibility to develop and provide the elements of sustainment for the forces it provides to the theater. CINCs may determine that common servicing would be beneficial within the theater or within a designated area. If so, the Service that is the dominant user of the service should usually be delegated responsibility for providing or coordinating the service for all Service components in the theater or designated area."

Comment. This happens in peacetime CSS day-to-day support operations for forward stationed units, but not enough in the deliberate planning process that creates OPLANS. Units must plan and train to accomplish this mission.

b. Chapter III. par 8(f). Operational Art and the Theater Campaign.

Text. "The level of sustainment within or available to the theater may place limits on timing and sequencing operations and battles. The CINC's logistics posture may force phasing and sequencing of operations to maintain the tempo of the campaign, ensure retention of the initiative, and keep the opposition off balance until all theater objectives are achieved. Early identification of critical logistic constraints to planned

operations is indispensable both to initiate intense efforts to find alternative solutions and to modify plans as required on a timely basis."

Comment. This paragraph does not specify joint medical and logistics planning. If the last sentence was expanded to state "alternative joint solutions", it would be emphasizing joint doctrine.

5. Test Pub JP 4-0, Doctrine for Logistic Support of Joint Operations, The Joint Chiefs of Staff, Washington, DC. June 1990.

PP.I-7,13 Health Services.

Text. "CINCs are responsible for coordination and integration of health service support within the command. Where practical, joint use of available medical assets will be accomplished to support the CINC's warfighting strategy and concept of operations....."

Comment. "Where practical", should be deleted and the word "maximum" added. This paragraph would be okay in the days of forward stationing, but not forward presence or crisis response.

As joint doctrine evolves, medical must be established as a functional area separate from personnel, operations, logistics, etc. It incorporates each of these functions, but its scarcity of resources and high visibility does not logically subordinate it to layers of decisions makers between the Commander and the Surgeon.

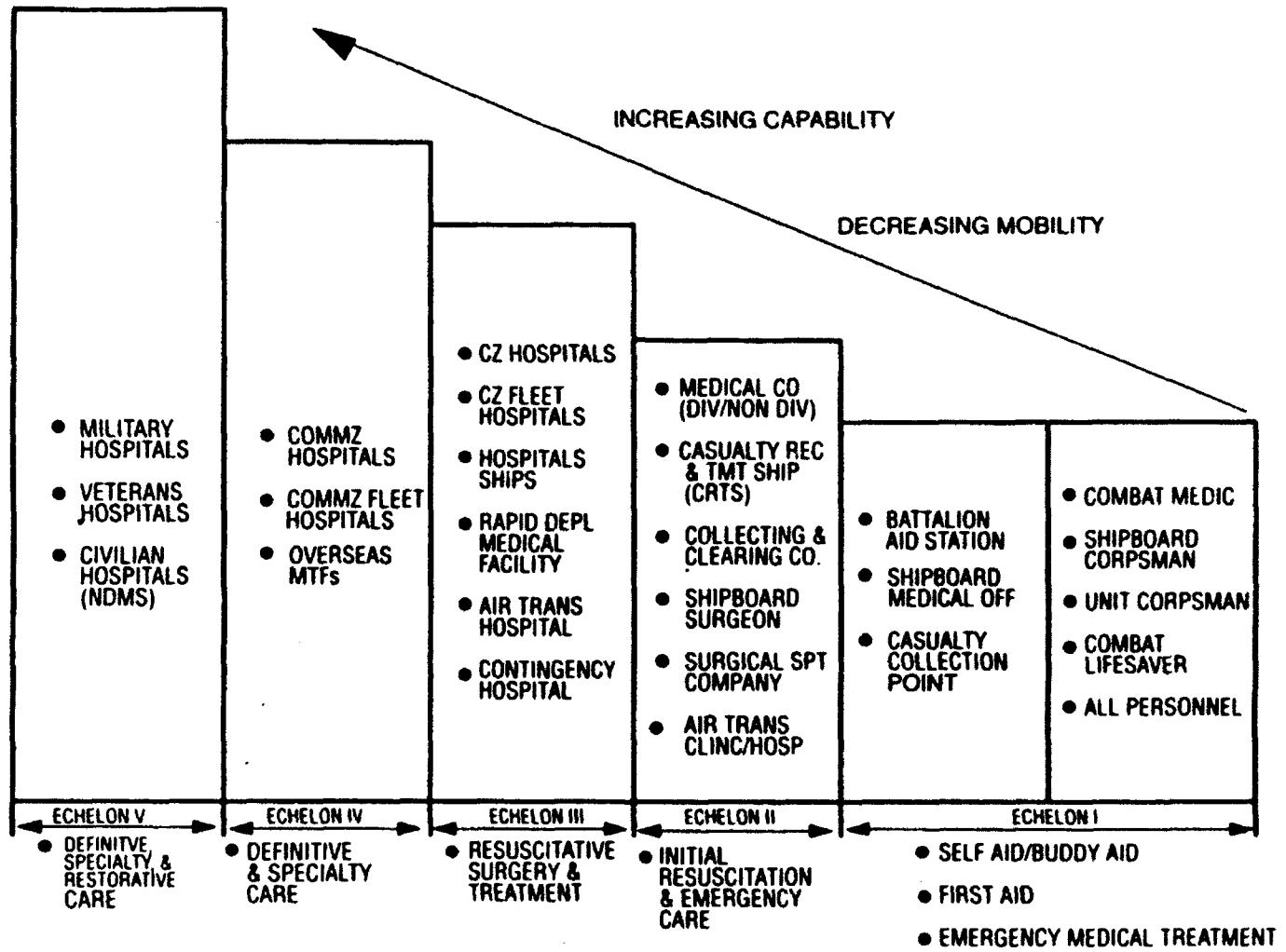
JOINT HSS DOCTRINE.

Since the 1980's the services' HSS have agreed jointly on a number of subjects. Many areas are deemed important, but for the purpose of this study three specific subjects standout. These imperatives to developing joint or a single HSS system are the Echelons of Care, Principles of HSS, and the Deployable Medical Systems (DEPMEDS)¹⁶.

The Echelons of Care are driven by the patient's condition and the operational environment, not the patient's service. Figure 1. displays the joint HSS system's Echelons of Care. These five levels of care extend from the point of wounding, injury, or illness through the theater of operation to CONUS. Each succeeding echelon (front to rear) possesses the same treatment capabilities as the one before it and adds another more sophisticated treatment capability to the system. The organizations providing the care are influenced by the mission, enemy, terrain, and such constraints as the availability of types of medical units, depending upon the tactical situations and operational environments.

The importance of the HSS Principles is the doctrinal planning and operational aspect, that all services' medical units are in congruence. Each service component has generally accepted these principles (these are summaries):

- a. Conformity. The medical plan must conform to the commander's strategic or tactical plan.
- b. Proximity. Provide HSS to the sick, injured, or wounded



Echelons of Care

as close to the combat operations as the tactical situation permits.

c. Flexibility. The HSS system must shift resources to meet changing requirements. There are no medical units in reserve.

d. Mobility. Through the use of organic and nonorganic transportation resources, commanders must be able to rapidly move HSS units to support combat operations.

e. Continuity. Provide optimum, uninterrupted care and treatment moving the patient through the progressive, phased HSS system.

f. Coordination. Continuous coordination ensures scarce HSS resources are efficiently employed to support the operation, not placed in areas that interfere with combat operations, and the scope and quality of care meets standards and policies.

The final action, which would be critical to a smooth consolidation of service medical assets into a single DoD HSA, is the development and fielding of the field hospital facilities designated as the Deployable Medical Systems (DEPMEDS). DoD Instruction 6430.1 dtd 21 June 1882, states the DoD policy on DEPMEDS. "In order to ensure maximum standardization, increase efficiency and minimize costs, DoD components shall acquire only those field DEPMEDS approved by the ASD(HA)".

Under the guidance of the ASD(HA), the Military Field Medical Systems Standardization Steering Group (MFMSSSG) established and validated a common database from which DEPMEDS could be standardized to the maximum extent possible. The panel

reviewed 309 patient conditions (PC), established tasks, procedures, the length of stay, and operating time for each PC at that echelon of care. Length of stay and surgical procedures were guided by the patient's condition as well as the Principles of HSS. This data was thoroughly scrutinized as the panels developed the original DEPMEDS database.

As a result, the DEPMEDS database provides the documentation for the clinical and logistical doctrinal policies by which the DEPMEDS Sets are built. Theoretically, the design of hospitalization and medical treatment units through the DEPMEDS database are based on the patient condition and the operational environment. This database is revised and approved by the ASD/HA and mandatory for each service to follow.

Given the acceptance of these principles, the echelons of care and the standardization of DEPMEDS; the planning of medical operations, whether a single HSA or separate services operating jointly, is greatly enhanced. It is when services begin to compete for resources to support operational plans that problems of inefficient duplication and gaps in the continuum of care arise. A single service HSA would preclude these problem.

PEACETIME HEALTH CARE DELIVERY.

As stated earlier some studies were long on peacetime health care delivery and short on readiness. This section is short and does not attempt to repeat all that has become obvious. It does

attempt to summarize what has occurred and integrate the peacetime HSS with the readiness aspect to provide a total HSS system.

In a briefing prior to his departure from office as the ASD(HA), Dr. Mendez stated, "that the DoD HSS system consists of 148 Hospitals, 554 Clinics, a \$15.3 billion program, and serves 8.4 million eligible beneficiaries". Unlike other combat and CSS functional areas, the downsizing of the armed services will not reduce this program appreciably.

Most of the peacetime health care delivery programs being implemented or tested in the military have existed for some time. These include coordinated care, managed care, catchment area management (CAM), enrollment, and other cooperative approaches. Until recently, none were implemented widely, particularly those requiring interservice cooperation in overlapping catchment areas (a CAM is the 40 mile radius of a hospital for which people are authorized to use that medical treatment facility [MTF]). These initiatives relied almost exclusively on local cooperation and initiatives. Proposals that threatened to diminish or infringe on military service autonomy and resource control were not pursued aggressively. Some were implemented without adequate planning, coordination, management, and the necessary follow-up required to ensure success. Furthermore, there were no incentives for improved performance.

The services recommended approach to solving these problems were cooperative boards, committees, and other ad hoc approaches

to ensure service independence and control over their respective resources. The majority of success cases were mostly MTF to MTF initiatives and not as larger inter-service efforts.

Today, the services embrace coordinated care and CAM (these are not all the programs being implemented) as major programs for cost containment and efficient health care delivery. Both initiatives are designed to maximize economies at the health care delivery level where there are major opportunities to contain costs and achieve other efficiencies. Some areas of concern are: required additional resources; local level incentive systems; needed administrative management restructuring; required management skills, i.e. financial and analytical expertise and medical contracting capability; and the distribution of authority required at the local MTF and catchment area levels. Some recommend ASD(HA) and the services should decentralize a greater degree of authority. Local commanders make more decisions and resource tradeoffs, consistent with local health care needs. Decentralization of authority by itself will not resolve the concerns listed. If policy development, resource management and program evaluation are centrally managed at the DoD level, this will provide that local commanders the necessary guidance and support to make those decisions which contribute to a total efficient HSS system.

The obvious is without CONUS facilities being assigned to a specific command, the amount of cooperation is always linked to how much it directly benefits the participating facilities.

Under one CONUS Health Service Command it gives the necessary guidance for those local commanders to maximize benefits for the total HSS system. It also simplifies the decision making process of specialty centers, teaching hospitals, and many other issues that previously relied on interservice cooperation.

WHERE WE ARE TODAY!

A letter from the Deputy SECDEF emphasizes the constraints on resources for the national defense and on DoD's medical mission with centralized authority and responsibility, but decentralized implementation by the Military Departments. It states, consistent with the principles stated in the SECDEF's July 1989 Report to the President on Defense Management, the medical mission of DoD is:

1. Maintain readiness to provide HSS to armed forces during military operations.
2. Provide HSS to members of the armed forces, their family members and others entitled to DoD medical care.

The ASD(HA) is responsible for the execution of this DoD mission. To exercise authority, direction, and control of medical assets in the services, ASD(HA) must go through the Secretary of the Services to the Military Departments or through the CJCS to the unified and specified commands. The ASD(HA) has nothing to do with the chain of command in the military departments, unified, or specified commands.

ASD(HA) is responsible for unified programming and budgeting to provide resources for all medical activities within DoD. This includes operations and maintenance, procurement, research and development, medical facility military construction, and the Civilian Health and Medical program of the Uniformed Services (CHAMPUS). It does not include funds for Active (AC) & Reserve Component (RC) medical military personnel.

In summary, ASD(HA) has the medical budget and responsibility, but must rely on the CJCS and Military Departments to execute programs and policies.

PLANNING MEDICAL SUPPORT.

Before consolidating HSS systems, it is best from a macro-planning process to review some possible contingency requirements and how the services' medical units operate. Then extract the best from each service to maximize the efficient consolidation of the HSS systems.

In a unified command, once requirements are estimated, the review process begins with in-country medical assets. A European or Korean scenario is different from a crisis response, due to the number of troops stationed there. Normally, medical assets forward stationed are only adequate to support in-place troops. First, determine if their capability can be expanded by deploying personnel rather than equipment. It takes 10 to 20 days to set-up any DEPMEDS hospital. The DEPMEDS hospitals can receive

patients earlier; but to become fully operational takes time, which may be critical to the campaign plan. Equipment prepositioned either in-country or afloat must be considered. Also, examine the deploying forces support assets. The Marines have a temporary hospital capability in the carrier battle groups and amphibious ships, but this is not designed to sustain other services or a large scale unified operation. Can these Navy assets be expanded to support other services? The Air Force deploys Air Transportable Hospitals (ATH) and the Hospital Surgical Expansion Package (HSEP) with its initial support packages. Although the ATH and HSEP are limited in capability, they arrive early and should be considered to support other services. Most Army hospitals with the possible exception of a MASH are deployed by sea. This is critical to planning, when developing the Time Phased Force Deployment List (TPFDL). The Navy Hospital ships will take twenty to thirty days to arrive anywhere, but once on station they are comparable to a COMMZ hospital.

Under the deployment objectives in crises response as outlined by the SECDEF; given a major regional crisis, the initial combined efforts of military and commercial airlift capabilities are used to transport the initial response forces. As they are delivered, priorities turn to other combat equipment needed to secure the airfield or ports and provide an adequate defense against the threat. Medical support to these forces is normally echelons I and II type units, unless there are Navy

ships off-shore. Then the problem is evacuating patients to the ship in a timely manner. Again, the only DEPMEDS hospital in the first arriving units are the USAF 50 bed ATHs; because the number of aircraft required to move other DEPMEDS hospital is too many for this critical deployment phase. With the limited hospital capability present, all aircraft become key to evacuating stabilized patients immediately out of the area, especially if it is a forced insertion.

Fast Sealift Ships (FSL) are used to move critical combat units of the early arriving units not part of a Maritime Preposition Ship (MPS) package. The next priority for movement is the additional ground forces that will complete the deployment of the Army corps. The only medical units that deploy with the Army divisions or MEFs are organic medical units, again only echelons I and II. DEPMEDS hospitals are containerized and are a part of MPS, but normally not more than one hospital per package. The remainder of DEPMEDS hospitals and other medical units' equipment will be brought into the theater by the Navy's Ready Reserve Force (RRF). The RRF includes RO/RO and break bulk ships as well as tankers and cranes which provide the surge for major operations.

Not all units go by sea. There are a myriad of smaller HSS units that can be interspersed throughout the air flow and normally are. The key essential units are the hospital and evacuation units and these must go by ship.

Now the strategy of prepositioning equipment becomes

critical to having the right units to medically support initial and early arriving forces. Hospitals are prepositioned with no problems; unfortunately, due to the engine seals etc., helicopters are not. Medical helicopters must be integrated into the flow to support the initial phases, either from the sea or as part of the combat units. A closer review of the roles of the Area Support Battalion (ASB), ATH, HSEP, Evacuation Battalion and the Navy's on board medical care must be conducted to solidify these phases of HSS.

As depicted by this brief review, it requires a total service effort to provide continuous medical support throughout an operation. So far the services have not been caught short. At least, documented short, due to loss of lives, because of inadequate medical support. If all assets are jointly reviewed and integrated into the plans, they will successfully facilitate the efficient, timely, and effective execution of military operations.

A SINGLE SERVICE HSS SYSTEM CONCEPT.

As stated previously, the studies that have reviewed the single DoD HSA concept have primarily focused on peacetime health care delivery and secondly, on the wartime mission. This study is based on the premise that the armed services' HSS system's primary mission is "Conserve the Fighting Strength". That requires a HSS system designed first to go-to-war and from that

basis the peacetime health care delivery system is built around that nucleus.

First, there are some salient points that are derived from the subject areas discussed, so far.

1. The services will continue to demonstrate parochialism when it comes to retention of their respective independent HSS systems. The reasons may be resource driven or pride and prejudice for their service. The reasons for parochialism are as true today, as they were in 1949.

2. The words "roles and mission" will continue to be mistakenly used for "duplication". This will lead to the SECDEF revising the latest "roles and mission" document. Not all duplication is bad. Some is even necessary.

3. Admiral Crowe's history lesson will continue to haunt the armed services, unless a review of functions is conducted with the objective of accomplishing the mission more efficiently, effectively, and without duplication, when feasible.

4. Forward presence and crisis response strategies drive deployment objectives making specific types of medical units based on capabilities, rather than service, critical to providing a continuum of care for the contingency operations.

5. The closer to the FEBA, the more a medical unit must be designed to support a specific service and survive in that environment. The further from the FEBA, the less service and more patient oriented the medical unit can be. It is the design of the unit, not its service that determines the level of patient

care provided.

6. If the desired end state is a DoD HSA, then there cannot be a single accountable entity for the Defense Health Program (DHP) when the services continue to be responsible for executing DoD medical programs. Budget and the authority to direct the execution of programs and policies go hand-in-hand.

7. The final point to remember when contemplating changes to the present DoD HSS system is, "there are no civilian or military HSS systems required to maintain, at such a high level, the balance between peacetime health care, readiness, and contingencies". There cannot be a comparison to just one aspect of the DoD HSS system. Any comparison must include all missions or it is not valid.

Based on the previous review, the approach is to develop a single DoD HSA by HSS functional areas. The following discussion of the HSS functional areas supports the U.S. Army as the DoD Executive Agent for this consolidation:

1. Hospitalization. Hospitalization has been simplified by the fielding of DEPMEDS. The pictorial display, at Figure 1 page 19, depicts the basic hospital doctrine for medical care at each level. DEPMEDS has modularized and standardized hospitals to the point that the services' assets are nearly identical. The differences are centered around surgical capability, number of beds and the mix of type beds. These hospitals can be combined, remembering the closer to the FEBA the more the hospital has to be designed to operate and survive in that environment. In the

COMMZ, there is a need for only one type of general hospital, because the requirements are more patient driven than designed for combat zone operations. As always, some hospitals will be designated as specialty centers (examples: burn center or neurosurgery) to concentrate scarce resources, but this is an augmentation to capabilities, not a different hospital.

The type hospitals that must be reviewed for design are those closest to the FEBA and the first to arrive as the initial response supporting air, land, or sea forces. These medical forces must support the deployment objectives and the ground transportation requirements, both air and ground. Regardless, whether there is a single HSA, there is still a requirement for the initial and early arriving hospital units to support all services. Today the services' hospitals, especially in the combat zone (CZ), are not designed to support anything other than their service. It is not even in the planning process. Under a single service concept these shortfalls would be resolved by designating the service with the most versatility in type hospitals- the Army. The Army is in the process of developing a true contingency hospital and could include in its design the requirements to support all services and meet the deployment objectives.

Peacetime health care delivery's most prominent shortfall is the authority to centralize control. Under this concept that will not be a question. All CONUS hospitals will be assigned to the Army's Health Service Command.

Some who opposed a single service will ask what about medical care to Air Force pilots or Navy submariners ? These are not issues. Aviation and subsurface medicine have been specialties for sometime. Their only requirements are for medical specialists trained in that field of medicine.

2. Area medical support. Area medical support consists of echelons I and II care provided to units without organic medical support. This does not include units in an Army Division or MEF. It is normally provided by units in the Corps Rear or COMMZ.

Figure 1. depicts some units providing a basic surgery capability at echelon II. This is where the echelons overlap in the services and its driven by scarce resources, tactical situation, and transportation. Historically and by design the level three hospitals are not prepared to accommodate outpatients, referrals and sick call during combat. They are also not designed to provide area coverage or respond to crisis in an area of operations. The Army's Area Support Battalions (ASB) are designed to do this mission plus other HSS functions. There are no comparable medical units in the Navy or Air Force to assume this mission.

The most important change, to the ASB's mission and design, is the additional task to support Army Divisions, MEFs, and Navy Surface Action Groups. This concept removes the organic medical assets from combat units in all services. It task organizes ASBs, giving them the functional and modular type medical treatment units to support the unified commander's forces, based

on mission, tactical location, and types of units supported. Once this unit is task organized, it is assigned to the unified command's Medical Command (MEDCOM) to support those forces identified until their mission changes. The objective of consolidating the medical assets is to provide the most efficient and effective HSS without duplication.

3. Patient evacuation and medical regulating. The amount of joint coordination in the unified commands centered on both patient evacuation and medical regulating has been tremendous. These two functions must operate closely to be efficient.

First, some key points about evacuation. Units with organic ambulances should not change, because these capabilities are based on the tactical situation. As the services move further from the FEBA, these evacuation assets can be combined into Evacuation Battalions (EB) to support all units. This consolidation would also resolve the issue concerning who provides helicopter evacuation support to the Marines, Navy hospital ships, and Air Force. Normally, the Army is tasked, but not authorized to plan and resource this mission. Additionally, the continuing problem of coordinating the scarce ambulance bus ownership and requirements for moving patients in-country to aeromedical staging facilities would be eliminated.

The Army has the only Evacuation Battalions (EB), presently in the force inventory. The major change in the EB's mission would be the movement of patients by Air Force and civilian aircraft. EBs would be task organized based on units supported

and location on the battlefield. OPCON of these units would be determined by the MEDCOM in accordance with the CINC's overall campaign plan.

Medical regulating is an intrinsic part of the evacuation process to insure patients are transported to the MTFs that can best care for them. The Armed Services Medical Regulating Office (ASMRO) and unified commands Joint Medical Regulating Offices (JMRO) have worked diligently to develop support systems for each theater and their unique problems. This has been a joint effort and does not require service ownership.

4. Medical Logistics. The Army has been appointed as the Single Integrated Logistics Manager in the European Command, Pacific Command, and Desert Storm. The only issue which has constantly delayed this system from being a total single service function is parochialism. The services have dodged resourcing and implementing it fully from the user to the depots in CONUS. There is no reason this has not been fully executed. It would save money and be more efficient. A single service HSA would resolve this issue.

5. Dental Services. This should not be an issue, only a matter of maintaining organic units where they are presently and reorganizing the area support units under central command. The Army has recently designed and began activating dental battalions which could provide this central command.

6. Blood Services. The Armed Services Blood Program Office (ASBPO) has been in effect for sometime supporting the unified

commands. It maintains and issues plans to coordinate the collection, processing, distribution, and management of blood products from CONUS to the theater of operations. It is thoroughly integrated into the blood services units, hospitals, medical logistic and transportation command's systems.

7. Veterinary Services. The Army is already the DoD Executive Agent for all veterinary services.

8. Preventive Medicine. The Army has teams organic to the ASBs providing this service. The key would be to review the authorizations versus requirements, because the new organization is already strained based on the peacetime and wartime requirements.

9. Laboratory Services. Medical units from echelon II through V have organic laboratory services based on the level of care they provide. The Army has developed area support laboratory units to augment hospitals and other missions such as preventive medicine and veterinary services. The other services do not have this capability. Including the other services in the system only requires reviewing workloads to consolidate those areas that would be more efficient.

10. Command and Control (C2). The present Army non-divisional C2 units consists of medical groups, brigades, and commands that can support Army divisions, MEFs, corps, joint task forces, or unified commands based on the mission and size of the force. For area medical support and C2 of preventive medicine, dental, and other services as determine, there are ASBs. The EBs

command all medical evacuation assets (unless organic to a specific type medical unit) and coordinate with the movement control centers at the various levels for nonmedical transportation assets. These units are presently in the force structure and require only modification to support other services as recommended previously. Authorizations for C2 units would be based on present basis of allocations and service equivalents to those allocations. This would be further refined as duplication of support is reviewed, revised, and eliminated.

The DoD Health Service Agency should be led by a civilian designated as an Assistant Secretary of Defense. This reinforces the concept that the "Health of the Command" is the Secretary of Defense's responsibility. It also precludes undue pressure from CJCS or the Chiefs of the Military Services over budget issues. The resourcing for all HSS assets belongs in this office. The CJCS, military services and unified commanders may submit supporting documents when HSS budget issues impact on their mission accomplishment.

The CJCS would provide guidance on joint doctrine, policies, procedures, and required support for unified commands OPLANs. Medical support to the unified commands would be accomplished through Medical Commands (MEDCOM). The difference being all medical services are assigned to the Commander, MEDCOM. Medical brigades, groups, EBs, and ASBs could be further OPCON to support the unified commander's campaign plans. The medical technical channels for policy and guidance that exist today would

remain in effect. This would ensure the coordinated and continued efficient resourcing of medical support for the unified commander.

The Air Force and Navy Surgeon Generals with reduced staffs would provide advice and assistance to the Service Secretaries and Chiefs. They would also advise the ASD(HA) on service doctrine and medical requirements.

The Army Surgeon General's (TSG) Office would be reorganized to establish U.S. Army Medical Command (USAMEDCOM). Initially, TSG would be dual hatted as Commander, USAMEDCOM and Surgeon General (SG) to the Army Service Secretary and Chief of Staff. It would not be in the best interest to split the TSG from these two roles during the transition. Later, it might be worth review. The split of the responsibilities would also provide a dedicated Surgeon General for advising the Army as the other services.

USAMEDCOM would consist of Health Services Command (HSC), responsible for all peacetime health care delivery in CONUS and the AMEDD School and Center, responsible for developing the doctrine, training, medical material, and other functional areas needed to provide medical support to all Services.

CONCLUSION.

The shear magnitude of demands that the national security strategy, national military strategy, peacetime health care

environment and military readiness requirements have placed on the DoD HSS system will by operational and budget necessity evolve the services into a consolidated HSS systems to achieve the myriad of missions. As resources are reorganized in the areas of headquarters, MTFs, catchment areas, numbers of type medical units, and overall better management; all savings, before they are declared, must be analyzed to insure that peacetime and readiness are addressed efficiently and effectively.

The key to Health Service Support to the Armed Services is unity of effort. For years a single service HSS system has been studied, discussed, and diluted by boards, committees, and handshaking. What has always lacked in these options is the the unity of effort. Joint services and cooperation only occurred, when it was to the services' advantage. Now as the services become smaller, types of missions more varied, and responses to the objectives more complicated; unity of effort means the difference between success or failure, life and death. As this study has demonstrated by reviewing the DoD Health Service Support system by functional areas, a single DoD Health Service Agency is feasible and the best method to conduct this consolidation is through one service as the Executive Agent- the United States Army. The United States Army Medical Department, as this process demonstrated, is already the sole functional supporter in many areas, the largest of the service HSS systems, and possess the infrastructure to accomplish the consolidation. The only hurdle is parochialism.

ACRONYMS

AMEDD Army Medical Department
ASB Area Support Battalion
ASD/HA Assistant Secretary of Defense/ Health Affairs
ATH Air Transportable Hospital
BRAC Base Realignment and Closure Act
SECDEF Secretary of Defense
CG Chairman Guidance
CINC Commander In Chief
CJCS Chairman, Joint Chiefs of Staff
CONPLAN Concept Plan
DEPMEDS Deployable Medical Systems
DHA Defense Health Agency
DHP Department of Health
DoD Department of Defense
DoD HSA Department of Defense Health Service Agency
DRMS Defense Resource Management Study
DPG Defense Planning Guidance
DVA Director of Veterans Affairs
EB Evacuation Battalion
FEMA Federal Emergency Management Agency
FORSCOM Forces Command
HSEP Hospital Surgical Expansion Package
HSS Health Service Support
JCS Joint Chiefs of Staff
JOPES Joint Operations, Plans, and Execution System

JOPS MPM Joint Operations and Planning System Medical Planning
Module
JS Joint Staff
MASH Mobile Army Surgical Hospital
MEDCOM Medical Command
MFSSSG Medical Field Systems Standardization Steering Group
MRC Major Regional Contingency
MTF Medical Treatment Facility
NCA National Command Authority
NDMS National Disaster Medical System
POC Point of Contact
Pub Publication
RO/RO Roll-on, Roll-off
RRF Ready Reserve Fleet
SASC Senate Armed Service Committee
SG Surgeon General
SRA System Research and Applications Corporation
TDA Table of Distribution and Allowances
TPFDD Time-Phased Force and Deployment Data
TPFDL Time-Phased Force and Deployment List
TO&E Table of Organization and Equipment
TSG The Surgeon General of the Army

ENDNOTE

1. A quotation taken from a briefing entitled, "The Fundamentals of Theater Warfare." This was part of developmental process for a case study developed on Desert Storm by the Advance Course students, USAWC Class of 1993. Instructor was Col (Ret.) Mike Morin.
2. Senator Sam Nunn. A Senate Floor Speech, The Defense Department Must Thoroughly Overhaul The Service Roles and Missions, Washington, D.C., 2 July 1992.
3. Joint Pub 4-02, Doctrine For Health Service Support in Joint Operations, The Joint Staff, Washington, D.C., 20 August 1991, (Test Pub), pp. I-1.
4. Colonel Richard H Ross, M.C., A Single Department of Defense Medical Service?, U.S. Army War College, Carlisle Barracks, Pa., 8 March 1963. pp. 16.
5. Review of the DoD Organization for Health Care, Director of Administration and Management, Directorate for Organizational and Management Planning, The Pentagon, Washington, D.C., March, 1991.
6. Col. Richard H. Ross, M.C., A Single Department of Defense Medical Service?, U.S. Army War College, Carlisle, Pa., 8 March 1963. U.S. Congress, Hoover Commission, Reorganization of the Federal Services, March 1949 and February 1959, known as: U.S. Congress, Hoover Commission, Federal Medical Services, First Report and Second Report.
7. Mr. Donald Rice, Secretary of the Air Force, Directed the "Defense Resource Management Study", The Pentagon, Washington, D.C., 1979.
8. Review of the DoD Organization for Health Care, Director of Administration and Management, Directorate for organizational and Management Planning, The Pentagon, Washington, D.C., march, 1991.
9. Fact Sheet, Goldwater-Nichols DoD Reorganization Act of 1986, Its impact on the Army, a Primer, AUSA, Arlington, Va., 1987.
10. Note. All references pp.6-7 from the FY 1989 Defense Authorization Act through November, 1990 Memo from the Deputy Secretary of Defense are extracts from the Director of Administration and Management study, endnote # 8.
11. Forces Command, CINCFOR CONPLAN 7300-90, Integrated CONUS Medical Mobilization Plan, Ft McPhearson, Georgia, 1 July 1990. (Unclassified).

12. Senator Sam Nunn. Senate Floor Speech, The Defense Department Must Thoroughly Overhaul The Services Roles and Mission.
Washington, D.C., 2 July 1993.

13. Dick Cheney, Secretary of Defense, Annual Report to the President and the Congress, U.S. Government Printing Office, January, 1993.

14. Dick Cheney, Secretary of Defense, Annual Report to the President and the Congress, U.S. Government Printing Office, January, 1993.

15. Taken from a copy of a TRADOC briefing slides entitled "The Army in Operations Other Than War", from U.S. Army War College Class of 1993, Advance Course, Evolving Joint Doctrine. Instructor Col. (Ret) Mike Morin. Carlisle Barracks, Pa. Feb, 1993.

16. The Echelons of Care and Principles of HSS are the author's summaries extracted from Joint Pub 4-02, (Test Pub), Doctrine for Health Services Support in Joint Operations, JS, 20 Aug 91. In both cases there has been some semantical changes made but not the level of medical support provided. The DEPMEDS information is extracted from, DEPMEDS Policies/Guidelines Treatment Briefs, approved by the ASD/HA, July, 1990.

BIBLIOGRAPHY

1. The White House. National Security Strategy of the United States. U.S. Government Printing Office. January, 1993.
2. Cheney, Dick. Secretary of Defense. Annual Report to the President and the Congress. U.S. Government Printing Office. January, 1993.
3. General Powell, Colin. Chairman, Joint Chiefs of Staff, National Military Strategy of the United States. U.S. Government Printing Office. January, 1992.
4. U.S. Congress, Hoover Commission, Reorganization of the Federal Medical Services, First Report. Washington, D.C. March 1949.
5. U.S. Congress, Hoover Commission, Reorganization of the Federal Medical Services, Second Report. Washington, D.C. 1955.
6. Senator Nunn, Sam. Senate Floor Speech. The Defense Department Must Thoroughly Overhaul The Services Roles and Missions. 2 July 1993.
7. Deputy Secretary of Defense. "Strengthening the Medical Functions of the DoD." Memorandum for Secretaries of the Military Departments, CJCS, and Under Secretary of Defense. The Pentagon. Washington, D.C. 10 October 1991.
8. Rice, Donald. Secretary of the U. S. Air Force. "Defense Resources Management Study." The Pentagon. Washington, D.C. 1979.
9. Assistant Secretary of Defense for Health Affairs. "Medical Programming Guidance-FY 1994-1999, Program Objective Memorandum." Draft Memorandum to Secretaries of the Military Departments. Washington, D.C. 24 January 1992.
10. Assistant Secretary of Defense for Health Affairs. "Deployable Medical Systems (DEPMEDS), Policies/Guidelines and Treatment Briefs." Memorandum for Chairman, Defense Medical Standardization Board. July, 1990.
11. Director of Administration and Management, Directorate for Organizational and Management Planning. Review of the DoD Organization for Health Care. The Pentagon. Washington, D.C., March, 1991.
12. Defense Medical Standardization Board, DoD ASD/HA. DEPMEDS Policies/Guidelines Treatment Briefs. Ft Deatrict, Maryland. July, 1990.
13. JCS Pub 0-2, w/Change 2. Unified Action Armed Forces (UNAAF). The Joint Chiefs of Staff. Washington, D.C. 21 April 89.

14. JS Admin Pub 1.1. Organization and Functions of the Joint Staff. The Joint Chiefs of Staff. Washington D.C. 1 October 1988.

15. JCS Pub 3-0, (Test Pub). Doctrine for Unified and Joint Operations. The Joint Staffs. Washington, D.C. January, 1990.

16. Joint Pub 4-0, (Test Pub). Doctrine for Logistics Support of Joint Operations. The Joint Staff. Washington, D.C. June, 1990.

17. Joint Pub 4-02, (Test Pub). Doctrine for Health Service Support in Joint Operations. The Joint Staff. Washington, D.C. 20 August 1991.

18. Joint Pub 4-02.1, (Test Pub). Health Service Support Logistics in Joint Operations. The Joint Staff. Washington, D.C. 15 April 1993.

19. Navel Warfare Publication 6 (Rev.C). Operational Medical and Dental Support. Department of the Navy. Office of the Chief of Naval Operations. Washington, D.C. March, 1989.

20. FMFM 4-50. Health Service Support. U.S. Marine Corps. Washington, D.C. 19 September 1990.

21. Forces Command. CINCFOR CONPLAN 7300-90. Integrated CONUS Medical Mobilization Plan. 1 July 1990. (Unclassified).

22. Briefing given by the Honorable Dr. Mendez, ASD(HA). Subject: "The Forces of Change, Development of a National Health Policy." 1992.

23. Col Ross, Richard H., M.C. A Single Department of Defense Medical Service? U.S. Army War College. 8 March 1963.

24. Ltc. Navin, Phillip. Organization of Department of Defense Medical Care. Office of the Secretary of Defense, 1 June 1990

25. Instructor: Col. (Ret) Mike Morin. The Fundamentals of Theater Warfare. A briefing and developmental process for a case study developed on Desert Storm by Advance Course Students, Class of 1993. Carlisle Barracks, Pennsylvania, 17013.

26. TRADOC Briefing "Operations Other Than War". 1993.

27. Fact Sheet. Goldwater-Nichols DoD Reorganization Act of 1986, Its Impact on the Army, a Primer. AUSA. Arlington, Va. 1987.